		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037234

Facility Name: TAYLORVILLE TERRACE

Address: 321 E. MARKET ST. (Number) TAYLORVILLE (City) 62568 (Zip Code)

County: CHRISTIAN

Telephone Number: (217)287-7787 **Fax #** (217)287-7743

IDPA ID Number: 363234108005

Date of Initial License for Current Owners: 08/02/91

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501©(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROB KEIME **Telephone Number:** (309)685-0595 EXT. 304

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,747			4,747	13
14	TOTALS	4,747			4,747	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.28%

D. How many bed-hold days during this year were paid by Public Aid?
128 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/02/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/08/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	16,381	2,404	1,618	20,403		20,403		20,403			1
2	Food Purchase		16,850		16,850		16,850		16,850			2
3	Housekeeping		2,692		2,692		2,692		2,692			3
4	Laundry		1,224		1,224		1,224		1,224			4
5	Heat and Other Utilities			11,026	11,026		11,026		11,026			5
6	Maintenance	7,234		8,567	15,801		15,801		15,801			6
7	Other (specify):*											7
8	**TOTAL General Services**	23,615	23,170	21,211	67,996		67,996		67,996			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400		4,400			9
10	Nursing and Medical Records	141,788	2,174	2,574	146,536		146,536		146,536			10
10a	Therapy											10a
11	Activities		1,489		1,489		1,489		1,489			11
12	Social Services			1,275	1,275		1,275		1,275			12
13	Nurse Aide Training	13,855	986		14,841		14,841		14,841			13
14	Program Transportation			1,441	1,441		1,441		1,441			14
15	Other (specify):* ROUTINE DENTAL			255	255		255		255			15
16	**TOTAL Health Care and Programs**	155,643	4,649	9,945	170,237		170,237		170,237			16
	C. General Administration											
17	Administrative	9,832		33,456	43,288		43,288		43,288			17
18	Directors Fees			2,847	2,847		2,847		2,847			18
19	Professional Services			13,537	13,537		13,537		13,537			19
20	Dues, Fees, Subscriptions & Promotions			2,511	2,511		2,511		2,511			20
21	Clerical & General Office Expenses		2,008	23,036	25,044		25,044		25,044			21
22	Employee Benefits & Payroll Taxes			43,624	43,624		43,624		43,624			22
23	Inservice Training & Education			11	11		11		11			23
24	Travel and Seminar			3,400	3,400		3,400		3,400			24
25	Other Admin. Staff Transportation			641	641		641		641			25
26	Insurance-Prop.Liab.Malpractice			8,194	8,194		8,194		8,194			26
27	Other (specify):*											27
28	**TOTAL General Administration**	9,832	2,008	131,257	143,097		143,097		143,097			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	189,090	29,827	162,413	381,330		381,330		381,330			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TAYLORVILLE TERRACE #0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			29,534	29,534		29,534		29,534			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,902	50,902		50,902	(6,662)	44,240			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			809	809		809		809			35
36	Other (specify):*											36
37	**TOTAL Ownership**			81,245	81,245		81,245	(6,662)	74,583			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			48	48		48		48			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,068	36,068		36,068		36,068			42
43	Other (specify):*			116,790	116,790		116,790	(116,790)				43
44	**TOTAL Special Cost Centers**			152,906	152,906		152,906	(116,790)	36,116			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	189,090	29,827	396,564	615,481		615,481	(123,452)	492,029			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(115,236)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(707)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,577)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(98)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(847)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,465)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (122,465)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

TAYLORVILLE TERRACE

ID# 0037234

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number TAYLORVILLE TERRACE **#** 0037234 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,675)	(22)	(965)	0	0	0	0	0	0	0	0	(6,662)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,675)	(22)	(965)	0	0	0	0	0	0	0	0	(6,662)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(116,790)	0	0	0	0	0	0	0	0	0	0	(116,790)	43
44	**TOTAL Special Cost Centers**	(116,790)	0	0	0	0	0	0	0	0	0	0	(116,790)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(122,465)	(22)	(965)	0	0	0	0	0	0	0	0	(123,452)	45

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
RESIDENTIAL CENTERS, INC.	100	SEE ATTACHED RELATED PARTY SCHEDULE	SEE ATTACHED RELATED PARTY SCHEDULE			
SEE ATTACHED SCHEDULE 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	OFFICE SUPP, TELEPHONE	$ 14,775	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT C	$ 14,775	$	1
2	V	22	EMPLOYEE BENEFITS	13,095	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	13,095		2
3	V	24	TRAVEL, SEMINAR	942	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	942		3
4	V	9	LICENSE , DUES & SUBS	310	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	310		4
5	V	25	VEHICLE EXPENSE	1	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	1		5
6	V	43	NONALLOWABLE	6	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	6		6
7	V	18	BOARD FEES	1,189	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	1,189		7
8	V	19	LEGAL & ACCOUNTING	4,474	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	4,474		8
9	V	35	RENT	809	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	809		9
10	V	32	INTEREST	264	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	242	(22)	10
11	V	30	DEPRECIATION	323	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	323		11
12	V	26	INSURANCE	91	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	91		12
13	V	9	UTILITIES/REPAIRS	77	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	77		13
14	Total			$ 36,356			$ 36,334	$ * (22)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	24	TRAVEL	$ 60	RESIDENTIAL CENTERS, INC,	100.00%	$ 60	$	15
16	V	18	BOARD FEES	1,923	RESIDENTIAL CENTERS, INC,	100.00%	1,923		16
17	V	21	OFFICE AND COMPUTER	2,930	RESIDENTIAL CENTERS, INC,	100.00%	2,930		17
18	V	22	EMPLOYEE BENEFITS	(85)	RESIDENTIAL CENTERS, INC,	100.00%	(85)		18
19	V	32	INTEREST	3,458	RESIDENTIAL CENTERS, INC,	100.00%	2,493	(965)	19
20	V	19	LEGAL & ACCOUNTING	7,415	RESIDENTIAL CENTERS, INC,	100.00%	7,415		20
21	V	20	LICENSE, DUES & SUBS	2	RESIDENTIAL CENTERS, INC,	100.00%	2		21
22	V	43	NONALLOWABLE	21	RESIDENTIAL CENTERS, INC,	100.00%	21		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,724			$ 14,759	$ * (965)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 7/30/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	RONALD SCHROEDER	PRESIDENT	BOARD MEMBEI	NONE	11,475	3HRS/ MTG		DIR. FEES	$ 525	L18, C8	1
2	DARRELL BOEHNE	VICE PRESIDENT	BOARD MEMBEI	NONE	9,182	3HRS/ MTG		DIR. FEES	418	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBEI	NONE	11,475	3HRS/ MTG		DIR. FEES	525	L18, C8	3
4	ROBERT BAUER	TREASURER	BOARD MEMBEI	NONE	4,430	3HRS/ MTG		DIR. FEES	370	L18, C8	4
5	CORA FLOTA	BOARD MEMBER	BOARD MEMBEI	NONE	4,724	3HRS/ MTG		DIR. FEES	76	L18, C8	5
6	ORLAND BAUER	BOARD MEMBER	BOARD MEMBEI	NONE	7,809	3HRS/ MTG		DIR. FEES	191	L18, C8	6
7	SHAWN JEFFERS	BOARD MEMBER	BOARD MEMBEI	NONE	5,276	3HRS/ MTG		DIR. FEES	324	L18, C8	7
8	MERLA MCCLOUD	RECORDER	ADMINISTRATIV	NONE	9,182	3HRS/ MTG		DIR. FEES	418	L18, C8	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,847		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RESIDENTIAL CENTERS, INC.
Street Address: 2020 W. WARMEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	24	TRAVEL	NUMBER OF BEDS	193	4	$ 720	$ 0	16	$ 60	1
2	18	BOARD FEES	NUMBER OF BEDS	193	4	23,200	0	16	1,923	2
3	21	OFFICE AND COMPUTER	NUMBER OF BEDS	193	4	35,348	0	16	2,930	3
4	32	INTEREST	NUMBER OF BEDS	193	4	30,071	0	16	2,493	4
5	19	LEGAL AND ACCOUNTING	NUMBER OF BEDS	193	4	59,841	0	16	4,961	5
6	20	LICENSE DUES	NUMBER OF BEDS	193	4	20	0	16	2	6
7	43	NONALLOWABLE	NUMBER OF BEDS	193	4	250	0	16	21	7
8										8
9										9
10										10
11	22	EMPLOYEE BEN/PAY TAXES	DIRECT METHOD						(85)	11
12	19	LEGAL AND ACCOUNTING	DIRECT METHOD						2,454	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 149,450	$		$ 14,759	25

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 7/1/2002 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CENTER FOR RESIDENTIAL MANAGEMENT
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFF CONST., SUPP & COMPUT	BEDS	335	18	$ 28,385	$	16	$ 1,356	1
2	19	PROFESSIONAL FEES	BEDS	335	18	38,969		16	1,861	2
3	24	TRAVEL SEMINAR	BEDS	335	18	5,082		16	243	3
4	20	LICENSE, DUES & SUB	BEDS	335	18	675		16	32	4
5	18	BOARD FEES	BEDS	335	18	16,800		16	802	5
6	32	INTEREST	BEDS	335	18	(36)		16	(2)	6
7	30	DEPRECIATION	BEDS	335	18	1,915		16	91	7
8	26	INSURANCE	BEDS	335	18	302		16	14	8
9										9
10	32	INTEREST	DIRECT METHOD						(22)	10
11	22	EMPLOYEE BENEFITS	DIRECT METHOD						12,756	11
12	21	OFFICE SUPP/TELEPHONE	DIRECT METHOD						(341)	12
13	20	LICENSE, DUES & SUB	DIRECT METHOD						259	13
14	24	TRAVEL SEMINAR	DIRECT METHOD						45	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,092	$		$ 17,094	25

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 7/1/2002 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CENTER FOR RESIDENTIAL MANAGEMENT
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFF CONST., SUPP & COMPUT	BEDS	331	17	$ 284,669	$ 186,143	16	$ 13,760	1
2	19	PROFESSIONAL FEES	BEDS	331	17	54,060		16	2,613	2
3	24	TRAVEL SEMINAR	BEDS	331	17	13,543		16	655	3
4	20	LICENSE, DUES & SUB	BEDS	331	17	393		16	19	4
5	18	BOARD FEES	BEDS	331	17	8,000		16	387	5
6	32	INTEREST	BEDS	331	17	5,493		16	265	6
7	30	DEPRECIATION	BEDS	331	17	4,795		16	232	7
8	26	INSURANCE	BEDS	331	17	1,586		16	77	8
9	25	VEHICLE EXPENSE	BEDS	331	17	16		16	1	9
10	43	NONALLOWABLE	BEDS	331	17	125		16	6	10
11	35	OFFICE EQUIP LEASE	BEDS	331	17	116		16	6	11
12	22	EMPLOYEE BENEFITS	BEDS	331	17	7,010		16	339	12
13	35	RENT	BEDS	331	17	16,614		16	803	13
14	6	UTILITIES AND REPAIRS	BEDS	331	17	1,598		16	77	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 398,018	$ 186,143		$ 19,240	25

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NCS HEALTHCARE, INC.		X	HARDWARE/SOFTWARE	$145.00	10/31/98	$ 5,783	$ 1,287	09/30/03	0.1429	$	1
2	BANK ONE BOND		X	ACQUISITION OF FACILITI	VARIES	06/25/98	2,584,836	791,645	07/01/19	VARIES	46,016	2
3												3
4												4
5												5
	Working Capital											
6				ALLOCATED FROM PARENT CO.							3,801	6
7				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(5,675)	7
8				MISCELLANEOUS INTEREST							98	8
9	TOTAL Facility Related				$145.00		$ 2,590,619	$ 792,932			$ 44,240	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,590,619	$ 792,932			$ 44,240	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** **N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number TAYLORVILLE TERRACE **#** 0037234 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	5,315	8
1999	901	9
2000	N/A	10
2001	N/A	11
2002	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TAYLORVILLE TERRACE COUNTY CHRISTIAN

FACILITY IDPH LICENSE NUMBER 0037234

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior BRICK W/ WOOD SII Frame WOOD Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENT CARE	14,000	1999	$ 20,000	1
2					2
3	TOTALS	14,000		$ 20,000	3

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1999	1991	$ 730,000	$ 18,250	40	$ 18,250	$	$ 79,083	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1993	1,930		7			1,930	9
10	LANDSCAPING			1994	1,790	179	10	179		1,702	10
11	FLOOR COVER			1994	3,152	315	10	315		2,993	11
12	GLIDER			1994	105	11	10	11		94	12
13	PATIO SET			194	600	60	10	60		510	13
14	TRASH TANK & BAFFLES			1998	2,435	162	15	162		893	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 740,012	$ 18,977		$ 18,977	$	$ 87,205	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 34,247	$ 3,557	$ 3,557	$	5-10 YRS	$ 22,901	71
72	Current Year Purchases	4,653	395	395		10 YRS	395	72
73	Fully Depreciated Assets							73
74	PARENT COMPANY		323	323				74
75	TOTALS	$ 38,900	$ 4,275	$ 4,275	$		$ 23,296	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORTAT	97 CHEVY ASTRO VAN	1998	$ 25,016	$ 5,003	$ 5,003	$	5	$ 25,016	76
77	RESIDENT TRANSPORTAT	95 FORD VAN	2002	SOLD	1,110	1,110		5		77
78	RESIDENT TRANSPORTAT	96 BUICK CENTURY	2003	3,375	169	169		5	169	78
79										79
80	TOTALS			$ 28,391	$ 6,282	$ 6,282	$		$ 25,185	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 827,303	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,534	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,534	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 135,686	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			894		894
3	Classroom Wages	(a)		4,506		4,506
4	Clinical Wages	(b)		9,349		9,349
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			92		92
9	TOTALS		$	$ 14,841	$	$ 14,841
10	SUM OF line 9, col. 1 and 2	(e)	$ 14,841			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	22
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	22

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): EYE CARE	L39, C3		48					48	13
14	TOTAL			$ 48		$	$		$ 48	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,105	$ 2,105	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,943))	129,342	129,342	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,699	2,699	6
7	Other Prepaid Expenses	83	83	7
8	Accounts Receivable (owners or related parties)	539,596	539,596	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 673,825	$ 673,825	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	730,000	730,000	14
15	Leasehold Improvements, at Historical Cost	10,012	10,012	15
16	Equipment, at Historical Cost	67,291	67,291	16
17	Accumulated Depreciation (book methods)	(135,686)	(135,686)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	197,237	197,237	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN FEES	39,707	39,707	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 928,561	$ 928,561	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,602,386	$ 1,602,386	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,744	$ 47,744	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,214	9,214	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,891	11,891	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	21,627	21,627	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	38,201	38,201	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 128,677	$ 128,677	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,287	1,287	39
40	Mortgage Payable			40
41	Bonds Payable	791,645	791,645	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 792,932	$ 792,932	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 921,609	$ 921,609	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 680,777	$ 680,777	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,602,386	$ 1,602,386	48

***(See instructions.)**

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 641,328	1
2	Restatements (describe):		2
3	PRIOR PERIOD AUDIT ADJUSTMENTS	(35,569)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 605,759	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	75,018	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 75,018	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 680,777	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 545,949	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 545,949	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	115,236	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	23,738	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,974	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,365	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,365	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	211	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 211	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 690,499	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	67,996	31
32	Health Care	170,237	32
33	General Administration	143,097	33
	B. Capital Expense		
34	Ownership	81,245	34
	C. Ancillary Expense		
35	Special Cost Centers	116,838	35
36	Provider Participation Fee	36,068	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 615,481	40
41	**Income before Income Taxes (line 30 minus line 40)****	75,018	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 75,018	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	1,968	1,968	13,855	7.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,049	2,171	16,381	7.55	15
16	Dishwashers					16
17	Maintenance Workers	878	998	7,234	7.25	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,034	935	9,832	10.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,570	1,664	21,818	13.11	29
30	Habilitation Aides (DD Homes)	16,231	17,031	119,970	7.04	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,730	24,767	$ 189,090 *	$ 7.63	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 1,499	L1, C3	35
36	Medical Director	MONTHLY	4,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	18	1,275	L12, C3	45
46	Other(specify)				46
47	PSYCHOLOGICAL	MONTHLY	2,574	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	42	$ 9,748		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDI LEONE	ADMINISTRATOR	0	$ 5,718
MELISSA FITZPATRICK	ADMINISTRATOR	0	4,114
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 9,832

B. Administrative - Other

Description	Amount
DEVELOPMENTAL SERVICES OF ILLINOIS, INC.	$ 33,456
ADMINISTRATIVE SERVICE FEES	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 33,456

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS, INC	U/C CONSULTATION	$ 425
LAWRENCE MANSON	LEGAL	986
BANK ONE/MARINE BANK	BOND FEES	3,768
AMERICAN EXPRESS T&B	ACCOUNTING	3,753
HEINOLD-BANWART	ACCOUNTING	131
PARENT COMPANY	ALLOCATION	4,474
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 13,537

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,274
Unemployment Compensation Insurance	5,793
FICA Taxes	15,409
Employee Health Insurance	10,579
Employee Meals	4,288
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE MORAL	281
TOTAL (agree to Schedule V, line 22, col.8)	$ 43,624

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	769
Health Care Worker Background Check	259
(Indicate # of checks performed 37)	
ILLINOIS HEALTH CARE DUES	890
VEHICLE LICENSE	78
MISCELLANEOUS DUES & FEES	140
MES MEMBERSHIP	175
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	3,223
Seminar Expense	177
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,400

**See instructions.

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number TAYLORVILLE TERRACE # 0037234 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC. $890**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **36,068**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,288** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **69%**
d. Have vehicle usage logs been maintained? **ADEQUATE RECORDS ARE MAINTAINED**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **HEINOLD - BANWART, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.